# Lead Report

*Medical Staff*

## Revised Joint Commission Standards For Medical Staff Operations Roil Industry

Revisions to medical staff accreditation standards published July 7 by the Joint Commission (JC) have spurred vociferous criticism in some quarters.

Two revisions in Medical Staff Standard 1.20 (MS.1.20) raised particular concern: 1) the mandate that certain accreditation requirements be in medical staff bylaws and 2) provisions critics claim undercut the authority of the medical executive committee (MEC) by allowing the medical staff to remove authority previously delegated to the committee, to extract and consider an MEC action prior to its becoming effective, and to recommend bylaws changes directly to the hospital board of directors, bypassing the MEC altogether.

John Horty of Horty Springer & Mattern PC in Pittsburgh expressed the views of many hospital law experts interviewed by BNA when he wrote in the firm's *Medical Staff Leader Monthly* that revised MS.1.20

> is a big step away from efficiency at a time when hospitals have much to concern them. The Joint Commission has set back hospitals and their medical staff leadership. It does the Joint Commission no credit nor does it advance their main agenda of quality patient care.

Michael R. Callahan of Katten Muchin in Chicago said of the requirement that all major substantive provisions be in bylaws approved by vote of the medical staff: "This is great for lawyers. It makes a lot of work. Amending the bylaws will take forever. Organized medical staffs, when they looked at it, said, 'This is crazy. Why would we want to put everything in the bylaws when it is so hard to change them?' It is hard enough now to find physicians to serve on the MEC. Who is going to want to be on a bylaw committee that is meeting every week?"

One attorney—critical of the change and pointing out that he and other health lawyers opposing the bylaws change are acting contrary to their own financial interest—provided BNA with this calculation: 5,000 hospitals' attorneys at $300/hour billing 25 hours apiece = $37 million. "While the equation is a stretch (some hospitals with house counsel may not have the same legal costs), cut it in half or even in quarters and it is still a lot of very unnecessary expense for a non-problem," he said.

However, American Hospital Association spokeswoman Nancy Foster had a completely different take. Foster, AHA vice president of quality and patient safety standards, told BNA the commission "respond[ed] to many of our concerns as well as those raised by clinician groups, and others. "They are trying to make it easier for folks," Foster said, "but, as in any process, changes make people look at things more carefully and that always raises questions."

Dr. Robert A. Wise, JC's vice president and director of standards and survey methods, firmly disagreed with complaints that "everything" must be put in the bylaws. The standards clearly state that only the requirements in Elements of Performance 9 through 33 are required to be in the bylaws, Wise said. "The procedures to effect these requirements may appear there or in the rules and regulations or policies." Furthermore, he added, for efficiency the organized medical staff can have the MEC approve of these procedures when they are put in the policies or rules and regulations instead of the bylaws.

The requirement/process distinction appeared to satisfy few. Horty Springer's Barbara Blackmond told BNA, "It makes no sense to separate the provisions from the 'procedural details'—the real world doesn't work that way." Besides, covering the same subject matter in two places is very cumbersome, she said.

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>
> CHARLOTTE S. JEFFRIES, HORTY SPRINGER, PITTSBURGH

Both Horty and Blackmond recommend that organizations that want to keep Joint Commission accreditation should just move everything back into bylaws.

"In our view, it isn't worth devoting valuable time or resources to figuring out which is which and where to put them," Horty said in his editorial. "Having important related provisions in two places is likely to lead to inconsistencies and confusion. The simplest way to address this latest pronouncement for those medical staffs that have adopted separate medical staff documents is to rename all documents as parts of the Medical Staff Bylaws."

To meet JC's implementation deadline for the revisions of July 1, 2009, however, the entire medical staff would have to vote on the new bylaws. "And that is where the paralysis comes in," Horty wrote. "Just getting a quorum for a vote is difficult for many medical staffs. Even with lower quorum requirements, mail ballots and electronic communications, it is an uphill battle for committed physician leaders to generate interest in the rank and file Medical Staff for most issues. The idea that hundreds of physicians will start coming to meetings and voting on bylaws is an illusion."

In a Horty Springer teleconference Sept. 20, Charlotte Jefferies told listeners that, for now, they should "do nothing." The standard is not effective until July 2009 and "we will be very disappointed if the commission does not change it" in response to industry reaction, she said. Susan LaPenta, also with Horty Springer, urged hospitals unhappy with the standard to tell the commission both why they want to keep their current documents and how those documents already advance

an effective working relationship among the organized medical staff, hospital management, and governing body.

**Medical Executive Committee Changes.** Horty said he found the language in the introduction to the revised standards relating to the relationship between the medical staff and the MEC "the most discouraging aspect of the revisions."

That language says: "The organized medical staff can take action to revise the authority it has delegated to the medical staff executive committee to act on its behalf. The organized medical staff is urged to determine what steps it will take if it does not agree with an action taken by the medical staff executive committee. Such steps might include a process that would allow the organized medical staff, at its discretion, to extract and consider an action by the medical staff executive committee prior to becoming effective."

An Aug. 22 "Open Letter" to the JC signed by Callahan, Blackmond, and six other prominent health law attorneys and published in the American Health Lawyers Association "Health Law Weekly" said that in reordering the existing governance relationship between the MEC and medical staff, MS.1.20 "seem to presume that hospital control of the MEC is the norm." This "extraordinary development ... ignores existing checks and balances which, to date, have worked to assure that the MEC represents the medical staff. How does this Standard promote efficiencies and a smooth operating medical staff when its elected leaders can be second guessed, bypassed and pre-empted?"

The letter urged that revised MS.1.20 be withdrawn and the draft submitted for field review in August 2006 be adopted instead. That draft left provision placement decisions to the medical staff and hospital and contained none of the final standard's governance changes.

**Other Side of Debate.** Not all health law attorneys see the revised standard as either a critical departure or an unnecessary interference in medical staff operations.

Speaking from the "medical staff/physician perspective," Michael A. Cassidy with Tucker Arensberg PC in Pittsburgh said at a Sept. 5 AHLA teleconference that MS.1.20 has been "well-received by organized medicine." As for complaints about how much work amending the bylaws will be, he said simply, "that it is difficult to do is no good reason not to."

Addressing the removal and extraction procedures, Cassidy asked "Why not? Why should the MEC have any more authority than the medical staff as a whole?" If a few doctors make a credentialing decision, he said, and "the medical staff looks at the same evidence and a group of 50 of them think that the three were wrong, why shouldn't they make the recommendation?"

Cassidy also spoke to the open letter's criticism that adapting to the new standard will be a "colossal waste of . . . effort" with no resulting improvement in patient care or hospital operations and to the complaint that the changes are a "solution" in search of a problem.

"Why this change?" he echoed. Like the description of the elephant by the blind men, everyone has a different opinion, Cassidy said. Recognizing that "I don't get called when relationships are working well," he said he believes there are problems. "I think there is enough concern from the medical staff perspective that they think they need to be protected in these relationships. Is JC accreditation and MS 1.20 the right forum? I think the reality is that this is the only forum." Medicare conditions of participation and a lot of the state licensing requirements talk about the need for involvement by the organized staff, he said. The bylaws "are where they are supposed to define their involvement."

"Overall, I think the idea of MS.1.20 is a laudable goal," Cassidy said, adding that one concern on behalf of the medical staff is that the process not become overly prescriptive and inadvertently undermine the process particularly with respect to ideas like veto, extraction, and direct access. "If we start with the principle that it's one doctor one vote or one voting member, the idea that there is a preemptive possibility does not overturn our regular concept of organizational structure."

**Joint Commission Responds.** Wise told BNA in July that MS.1.20 is "going to continue to be one of the most misunderstood standards" and that confusion can be avoided only by a precise reading of the standard in conjunction with the JC's Leadership Standards. "However, I can tell you . . . we would never have put something this substantial [in the standards] without having multiple conservations and, in fact, having people in the same room representing the American Medical Association and the AHA. We have done this incredibly carefully and many of the major stakeholders have walked along with us the entire way. "

Two months and many complaints later, however, JC General Counsel Harold J. Bressler appeared more sensitive to the growing dissension. Participating in the Sept. 5 AHLA teleconference, he assured listeners that "we are not ignoring the controversy led by health care lawyers over MS.1.20." He also announced an Oct. 24 national audio conference with JC-accredited organizations during which "we want to make sure we miss none of your issues."

In a published response to the open letter, he reassured interested parties that all commission standards are promulgated and applied solely to help enhance quality and safety and that surveyors will apply MS.1.20 with a "flexibility" that also will "contemplate The Joint Commission empathetically dealing with the resource expenditure issue."

Bressler also addressed the question of what problem MS.1.20 is intended to cure. Maybe "the better question is whether organized medical staffs are working across this country with governing bodies and management in the best ways to enhance quality and safety as contemplated by not only Joint Commission standards but also law and regulation," he said.

Withholding judgment on the revisions for now, Douglas A. Hastings of Epstein Becker & Green in Washington told BNA Sept. 19, "Perhaps the upcoming discussions will shed some light on how the commission is going to make the case for that linkage to quality and the need to put hospitals and their medical staffs through a round of change." He said he sees the heart of the debate as "how to balance achieving quality and a hospital's need to oversee quality while at the same time dealing efficiently with fairly complex structural issues."

One thing is clear: The debate will be long and intense. "This is one big roller-coaster ride, and it is not over yet," Jeffries said.

By Susan Carhart

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